Calendar Year 2022 (CY22)
Medicare Part C Improper Payment Measure (Part C IPM)

MEDICAL RECORD SUBMISSION INSTRUCTIONS

January 18, 2024

SUBMISSION DEADLINE: May 9, 2024 at 11:59 p.m. PT

Contents

Calendar Year 2022 (CY22) Medicare Part C Improper Payment Measure (Part C IPM) Background and Requirements

Your Medicare Advantage (MA) Organization is required to submit medical records for each enrollee to validate the sampled Centers for Medicare & Medicaid Services-Hierarchical Condition Categories (CMS-HCCs) (42 C.F.R. § 422.310(e)). Review of these records for the Medicare Part C Improper Payment Measure (Part C IPM) allows CMS to comply with the Payment Integrity Information Act of 2019 (PIIA), which requires CMS to annually measure and report a Medicare Part C improper payment estimate. Your cooperation with this Part C IPM activity, including following these submission instructions, is critical.

MA Organizations with beneficiaries selected for the Calendar Year 2022 (CY22) Part C IPM (for fiscal year 2024 reporting) will have until **11:59 p.m. PT on Thursday, May 9, 2024** (the "submission deadline") to complete submissions to CMS using the Part C IPM module in the Health Plan Management System (HPMS). No submissions will be accepted outside HPMS, and no submissions will be accepted after the submission deadline. Please note that CMS will only consider hardship exception requests in truly extraordinary circumstances, such as a natural disaster. In order to request a hardship exception, your MA Organization must use the request form contained in the HPMS Part C IPM Document Library. All hardship requests must be submitted to CMS no later than 11:59 p.m. PT on Thursday, April 25, 2024.

Your sampled enrollees are identified on your Enrollee List within your HPMS Part C IPM Document Library. The Enrollee List includes enrollee identifiers, such as enrollee name and ID, CMS-HCCs for validation, and MA contract information. **Note:** For the CY22 Part C IPM, one or more enrollees with End-Stage Renal Disease (ESRD) may be included in the Enrollee List. Under the 21st Century Cures Act, enrollees with ESRD became eligible to enroll in MA starting in CY21.

Your MA Organization is required to request medical records from hospitals and physicians/practitioners who provided services to your sampled enrollees and documented one or more diagnoses associated with your enrollees' CMS- HCCs during the appropriate data collection period. The data collection period for the CY22 Part C IPM activity is **January 1, 2021 through December 31, 2021**.

For CY22, CMS uses the 2020 CMS-HCC model (also known as the V24 model) for non-ESRD enrollees and the 2020 ESRD model (or V21 ESRD model) for ESRD enrollees. CMS calculates 100% of the risk score with the V24 CMS-HCC and V21 ESRD models, using diagnoses from encounter data and Fee-for-Service (FFS). Please refer to the CMS 2022 Announcement, https://www.cms.gov/files/document/2022-announcement.pdf, for more detail.

You will need to pair each medical record you submit with a Medical Record Coversheet that is generated by the Part C IPM module in HPMS. The medical record and the accompanying Medical Record Coversheet (and, if needed, a CMS-Generated Attestation for medical records lacking the necessary provider signature and/or credentials) comprise the supporting documentation for submission to CMS. Although several International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes that map to a CMS-HCC may be listed on a Medical Record Coversheet and Enrollee List, your MA Organization is required to submit a medical record that validates the unique enrollee CMS-HCC, not each ICD-10-CM code. **For enrollees with multiple sampled CMS-HCCs, you may have a medical record that documents more than one CMS-HCC. In this case, you should select all applicable CMS-HCCs when completing the Medical Record Coversheet and submit the record only once**. Please avoid submitting the same medical record documentation multiple times for the same or different CMS-HCC(s). CMS considers these as duplicate submissions and will not review them.

Once medical records have been submitted to HPMS and the intake process is complete, coders will

review the medical records based on the date (for physician/hospital outpatient records) or range of dates (for inpatient and observation records) that your MA Organization enters on the Medical Record Coversheet. The coders will abstract all valid ICD-10-CM codes in the documentation within the specified dates or date of service indicated on the Medical Record Coversheet.

MA Organizations must submit supporting documentation via the Part C IPM module within HPMS. HPMS is the only acceptable forum for submitting supporting documentation for CY22 Part C IPM. HPMS supports access via the latest versions of Chrome, Firefox, and Microsoft Edge. For Mac users, while most HPMS system functionality runs properly in Safari, users may encounter issues. As a result, CMS recommends that users accessing HPMS on a Mac use the Firefox browser to ensure full system functionality.

Throughout the medical record submission process, limit disclosure of protected health information (PHI) and personally identifiable information (PII) to the minimum necessary to accomplish the intended purpose of the Part C IPM. Instruct your providers to communicate only with your MA Organization regarding the availability and transmission of medical records. Include your MA Organization's contact information with all provider communications, especially facsimile communications. **Providers must submit documentation directly to your MA Organization. Providers must not submit documentation directly to HPMS or CMS.** Please note that, to avoid data breaches, when communicating with CMS about a specific enrollee, MA Organizations must use the Part C IPM Enrollee ID and not the enrollee's name. You can find Enrollee IDs for all selected enrollees in the Enrollee List, available in the HPMS Part C IPM Document Library.[1] As always, do not submit any material containing PHI and PII via email. Incidents of compromised PHI and/or PII will be reported to the CMS Computer Security Incident Response Team as described in the CMS Risk Management Handbook Version 2.1, Chapter 08: Incident Response (dated 03/23/2021).

These submission instructions provide guidelines regarding criteria for MA Organizations to consider when selecting medical records, CMS-Generated Attestations, preparing the Medical Record File, and checking the Medical Record File before submission. The *HPMS Part C IPM Module User Guide* provides technical instructions for using the Part C IPM module within HPMS, such as instructions for accessing the site, showing screenshots of how to navigate in the module, and how to access reports. MA Organizations are encouraged to view file format feedback and validity feedback within HPMS during the submission period. Your MA Organization will also receive two (2) interim findings reports (IFRs), which will provide interim coding results on submissions. Additionally, plans have access to the Part C IPM *HCC Outcomes Detail Report* in HPMS, which displays a list of all CMS-HCCs reviewed within the sample, preliminary CMS-HCC outcomes, and MA Contract Suggested Action to the plan user. This feedback should be used to submit or resubmit another medical record prior to the submission deadline. Refer to the Feedback Available Within HPMS section for more information.

[1] Please see the entry for *CMS-HCC for Validation* in the Enrollee List Data Dictionary on the HPMS Part C IPM Document Library for more information on the set of sampled CMS-HCCs for CY22 Part C IPM.

Requesting Medical Records from Providers

Resources for MA Organizations to Use to Contact Hospitals and Providers
CMS provides a number of resources to facilitate your MA Organization's efforts to contact hospitals and professional providers for medical record documentation for the CMS-HCC(s) sampled for CY22 Part C IPM. The following documents are available in the HPMS Part C IPM Document Library:

- *Physician Letter* and *Hospital Letter Templates*: Letter templates for use by MA Organizations when contacting physicians/practitioners and hospitals. These letters describe the overall purpose and background for the CY22 Part C IPM activity and specifically address Health Insurance Portability and Accountability Act (HIPAA) issues related to the request of medical records for this project. Please note that the Physician Letter and Hospital Letter may **only** be shared with providers for the purpose of CY22 Part C IPM, and **not for any other purposes**.
- *Health Insurance Portability & Accountability Act (HIPAA) Fact Sheet*: This document is included as additional information with the Physician Letter and the Hospital Letter.

MA Organizations are not required to use the HIPAA Fact Sheet or the letter templates, although MA Organizations have found that use of these documents alleviates common questions about the Part C IPM activity and HIPAA rules and assists in obtaining medical records. If you do send these documents to your physicians and hospitals, please be sure to send both pages. If you choose to use your own communications, please make clear the purpose of the medical record request and that all correspondence must be directed back to the MA Organization and **not** to CMS.

Selecting a Medical Record

This section provides information on selecting medical records to submit for validation. The following items are addressed:

- General guidance for selecting a medical record;
- Identifying medical records that support sampled CMS-HCCs; and
- Identifying medical records that meet the dates of service, provider type, acceptable physician specialties, signature types, and credential requirements.

General Guidance for Selecting a Medical Record

Your MA Organization must select a medical record to support each sampled CMS-HCC. A medical record for the purposes of the CY22 Part C IPM is documentation that verifies a single face-to-face encounter with a physician/practitioner office or hospital outpatient visit, observation stay, or a single admission for a hospital inpatient visit.[2] **Note:** As a result of the COVID-19 emergency declaration blanket waivers CMS has issued, telehealth visits for CY22 dates of service (January 1, 2021 – December 31 2021) will be considered equivalent to face-to-face visits. The documentation should reflect the same standard of care as an in-person visit.

The requested medical records must be selected from an inpatient hospital, outpatient hospital, observation, or physician/practitioner that is acceptable for risk adjustment (see Appendix A: CMS-HCCs and Physician Specialties). If your MA Organization finds more than one medical record (from multiple provider types and/or dates of service) to support a given enrollee CMS-HCC, your MA Organization must select only one (1) of those records for initial submission (i.e., a single date of service [outpatient], range of dates [observation], or a single admission [inpatient]). Each Medical Record File may contain only one (1) CMS-Generated Attestation (if applicable), and one (1) medical record.

Follow the below guidelines when selecting medical records for submission:

- For the sampled CMS-HCC, submit a medical record that documents all diagnoses submitted by your MA Organization for payment by CMS. The source of diagnoses for CY22 is the Encounter Data System (EDS), and no diagnoses from the Risk Adjustment Processing System (RAPS) will be used, according to the policy change that CMS implemented for risk-adjusted payments starting in CY22. Ensure the medical record documents a face-to-face visit. Refer to the "Note" above regarding valid face-to-face visits for the CY22 Part C IPM.
- This medical record must contain dates of services between January 1, 2021 and December 31, 2021. For hospital inpatient medical records, the discharge date must be in 2021 to be considered within the relevant timeframe.
- Hospital inpatient medical records must display an admission date, discharge date, and contain a signed Discharge Summary (or a Discharge Note for admissions less than 48 hours).
- Submit a medical record from an acceptable risk adjustment provider type (hospital inpatient, hospital outpatient, or physician only) (see Appendix A: CMS-HCCs and Physician Specialties).
- Check that the medical record has a legible physician/practitioner signature and appropriate credential. If this is not the case, submit a CMS-Generated Attestation (provided in the HPMS Part C IPM Document Library) for the physician/practitioner office or hospital outpatient visit. See section below on CMS-Generated Attestations. No attestations are acceptable for inpatient records.

[2] For the purposes of Part C IPM, the terms "hospital inpatient" and "hospital outpatient" have the same meaning and include specific facilities listed in Medicare Managed Care Manual Chapter 7: Risk Adjustment, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf.

- Do not alter the medical record.
- Do not create PDF images of medical records containing adhesive notes or highlighting, as these items may cause the text of the medical record to be obscured or misunderstood. Adhesive type notes or paper clipped notes included on the medical record are not considered during medical record review.
- If the condition warrants an inpatient hospitalization, the CMS-HCC may be supported by an inpatient record. Examples of such conditions may include septicemia, cerebral hemorrhage, cardio-respiratory failure, and shock.
- When possible, obtain a medical record from the specialist treating the condition (e.g., an oncologist for a cancer diagnosis). These medical records may be more likely to sufficiently document the condition.
- Pay special attention to cancer diagnoses. Annotations indicating "history of cancer," without an indication of current cancer treatment may not be sufficient documentation for validation. For example, if your MA Organization submits a medical record that indicates a patient has a history of cancer that was last treated outside the data collection year, the CMS-HCC may not be validated.
- When selecting medical records for submission, pay special attention to the problem list on electronic medical records. Coders will only consider those conditions on problem lists that are currently active when reviewing the record to validate the CMS-HCC(s). Often, in certain systems, a diagnosis never drops off the list even when the patient is no longer living with the condition. Conversely, the problem list may not document the CMS-HCC your MA Organization submitted for payment.
- Any problem list should be included in the Medical Record File and not only referenced.
- Medical records submitted to validate CMS-HCCs that encompass additional manifestations or complications related to the disease should include language from an acceptable physician specialty that establishes a causal link between the disease and the complication. An acceptable medical record that clearly defines the complication or manifestation and expressly relates it to the disease may validate the CMS-HCC. A medical record that does not do so may not validate the CMS-HCC.
- If your MA Organization is unsure whether a medical record contains sufficient documentation to validate the sampled CMS-HCC and there is no better medical record, CMS recommends submitting the medical record for review; it may be determined that the medical record does in fact support the CMS-HCC being validated.

Note: If your MA Organization does not have a medical record to support an audited CMS-HCC(s), it should select the "No document will be attached for selected CMS-HCC(s)" radio button when completing the coversheet during the submission process in HPMS. Your MA Organization will be required to provide a brief explanation detailing why medical record documentation will not be submitted for the selected CMS-HCC(s). If documentation is found during the submission window, your organization may generate a separate coversheet with documentation attached. Please note that CMS-HCCs without a valid medical record submitted will be marked as discrepant.

Selecting a Medical Record that Validates Sampled CMS-HCCs

Diagnoses and CMS-HCCs Used for Payment

Although several ICD-10-CM codes that map to a CMS-HCC may be listed on a Medical Record Coversheet and Enrollee List, your MA Organization is required to submit a medical record that validates the unique enrollee CMS-HCC, not each ICD-10-CM code. Independent coders will abstract all ICD-10-CM diagnosis conditions within the specified dates of service from the medical record submitted. Those diagnoses that map to payment CMS-HCCs must be:

- Documented in the medical record and as a result of a face-to-face visit (refer to the "Note" on page 6 regarding valid face-to-face visits for the CY22 Part C IPM);

- Coded in accordance with the *ICD-10-CM Guidelines for Coding and Reporting*, and American Hospital Association (AHA) Coding Clinic Guidelines;
- From a date of service between January 1, 2021 - December 31, 2021; and
- From an appropriate risk adjustment provider type (hospital inpatient, hospital outpatient or physician), and an acceptable physician specialty (see Appendix A: CMS-HCCs and Physician Specialties).

CMS-HCC Hierarchies

MA Organizations should submit a medical record that best supports the enrollee's sampled CMS-HCC(s). A CMS-HCC may be substantiated at a varying severity than the sampled CMS-HCC. Even if CMS cannot substantiate the sampled CMS-HCC, CMS may be able to substantiate another CMS-HCC in the hierarchy. Furthermore, it is possible that CMS would be able to substantiate the sampled CMS-HCC and avoid a discrepant finding entirely; and if a CMS-HCC of a lower severity is found supported by the medical record, the discrepant finding, and therefore the associated payment error, would be lower.

Additional information on hierarchies can be found in Appendix A: CMS-HCCs and Physician Specialties.

Common Reasons CMS-HCCs are Not Found

CMS' Part C IPM medical record reviewers have noted the following medical record documentation issues from past samples, which lead to discrepant CMS-HCCs:

- **Diabetes Mellitus documented without complications**: Diabetes was not linked with any complication that would result in CMS-HCC18 in the medical record. Confirm complications are documented when selecting a record to support CMS-HCC18.
- **No documentation of Dependence or of a related disorder**: Medical record did not document dependence or a related disorder. When submitting documentation to support CMS-HCC54/55 (Drug/Alcohol Dependence) or CMS-HCC82 (Ventilator Dependence), confirm dependence or a related disorder is documented.
- **Cerebral Vascular Accident (CVA) was documented in a subsequent visit**: Medical record documented CVA in a subsequent visit. When submitting documentation to support CMS-HCC100 (CVA) or CMS-HCC103 (Hemiparesis), ensure the diagnoses are documented in the **initial** encounter.
- **Past acute condition listed; not under current treatment**: For multiple CMS-HCCs in past samples, acute conditions were listed on a Problem List and no longer under current treatment. Ensure the documentation indicates the acute condition is under **current treatment** to validate the CMS-HCC.
- **Cancer documented as history; no current treatment documented**: For CMS-HCCs 8/9/11/12, documentation must indicate cancer is still under **current treatment**. Carefully review documentation to ensure cancer is not listed as history or indicates the cancer is no longer present.
- **Diagnosis listed as possible on an outpatient provider**: For multiple CMS-HCCs in past sample documentation, the diagnosis was listed as "rule out" or with other language indicating the diagnosis was not confirmed. Ensure the diagnosis is not listed with non-confirmed language.
- **Body Mass Index (BMI) documented but no associated diagnosis documented**: The medical record listed a BMI of over 40 but did not list the associated diagnosis of obesity. Ensure the diagnosis of obesity must be listed when validating CMS-HCC22.
- **Excludes 1 Note prevented assignment of code**: For multiple HCCs, a coding guideline prevented coding the diagnosis. An Excludes 1 note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note. An Excludes 1 note is used when two conditions cannot occur together (for example, a congenital form versus an acquired form of the same condition).

Date(s) of Service, Physician Specialty, Credentials, and Signatures

All medical records that are submitted should be signed and dated by a provider with an acceptable risk adjustment physician specialty (or in the case of physician/practitioner office and hospital outpatient visits, if the medical record is not properly signed and dated, attach a completed CMS-Generated Attestation).[3] Sometimes medical records contain the necessary diagnosis information to support sampled CMS-HCCs, but the signature and/or credentials from the physician/practitioner who conducted the health service are missing. Medical records submitted for CY22 Part C IPM that do not contain signatures or physician/practitioner credentials will result in errors under the medical record review process.

Dates of Service

- Medical records submitted for CY22 Part C IPM must have a clear date of service within the data collection period.
- The data collection period for CY22 Part C IPM is January 1, 2021 through December 31, 2021. For inpatient medical records, if the admission date is in 2020, the discharge date must be in 2021.
- Although medical records with discharge date after 12/31/2021 are not acceptable for submission for CY22 Part C IPM, you have the option to submit any physician encounters that occurred during an inpatient visit with discharge date between January 1, 2021 and December 31, 2021 separately as physician records. Accordingly, documentation such as the admit note, history and physical, consultations, operative reports, or progress notes that (a) support the sampled CMS-HCC, (b) meet risk adjustment criteria for signature/credential, (c) are clearly dated between January 1, 2021 and December 31, 2021, and (d) are from an acceptable provider specialty may be submitted, each with a Medical Record Coversheet for one Physician or Hospital Outpatient date of service.

Physician Specialty and Credentials

- Medical records submitted for Part C IPM must be from an acceptable physician specialty (see Appendix A: CMS-HCCs and Physician Specialties) and must be authenticated by the provider. Each record must have a signature and physician specialty credentials. The credentials for the provider must be somewhere on the medical record; for example, next to the provider's signature or pre-printed with the provider's name on the practice's stationery. If the credentials of the physician/practitioner are not listed on the stationery, then the credentials must be part of the signature for that provider.

Signatures

Acceptable physician authentication comes in the form of handwritten signatures and electronic signatures. Stamped signatures are not acceptable.

- Electronic signatures are an acceptable form of medical record authentication, provided that the system requires the provider to authenticate the signature at the end of each note. Some examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," or "Validated by," and include the physician/practitioner's name (including credentials) and date signed.
- All medical record entries must be complete and must be authenticated and dated promptly by the provider who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and authenticated by their credentials. Regardless of the provider type, a consultation report with the typed name of the dictating physician/practitioner should also include the signature of the dictating physician/practitioner.
    - For Physician Specialist/Hospital Outpatient records: Hospitals often release copies of dictated reports prior to obtaining the responsible provider's signature. These reports

[3] See the CMS-Generated Attestations section of this document, which may be used to correct signature and date deficiencies for Physician Specialist/Hospital Outpatient records.

then are filed in another physician's record in an "acceptable" form as previously indicated. Diagnoses from these reports would be coded and abstracted from a physician record when either of the following conditions applies: 1) the physician has referenced the report diagnosis as part of his/her documentation in the office record; or 2) the report to which the physician is referring is signed and valid as a stand-alone encounter in the data collection period. If a medical record has a missing or illegible physician/practitioner signature and/or credential, the MA Organization should use the CMS-Generated Attestation located in the HPMS Part C IPM Document Library.

- For Observation records: For medical records documenting an observation stay, a typed signature alone is not acceptable. It must be signed/authenticated by the provider dictating the report or a supervising physician in the case of a scribe. If there are unsigned notes within the submitted record, the coder may only use the signed documentation to appropriately code the diagnoses on the record.
- For hospital inpatient discharges: For medical records documenting hospital inpatient visits, a typed signature alone is not acceptable. It must be signed/authenticated by the provider dictating the report or a supervising physician in the case of a scribe. Within a lengthy inpatient record, there may be a few unsigned progress notes or unsigned consultation reports. If the record is an inpatient medical record with sufficient signed documentation in the record to substantiate the diagnosis, the coder may use the signed documentation to appropriately code the principal and secondary diagnoses for the enrollee's discharge.

Submitting a Discharge Summary

A Discharge Summary may be submitted as a "Physician Specialist/Hospital Outpatient" record or as a "Hospital Inpatient" record type.

- The medical record is documentation of a face-to-face visit (refer to the "Note" on page 6 regarding valid face-to-face visits for the CY22 Part C IPM). For this reason, a Discharge Summary may be considered a face-to-face visit with an acceptable physician provider type for the date of discharge that is indicated on the Discharge Summary and Medical Record Coversheet. In this instance, when submitting the record in the Part C IPM module, select that a "Physician Specialist/Hospital Outpatient" record is attached, to be reviewed using Outpatient Coding Guidelines.

Note: Do not confuse a dictation date with the discharge date. There must be a separate discharge date indicated on the submitted medical record.

If you choose to submit a Discharge Summary as a standalone "Hospital Inpatient" record, it must contain both the admission and discharge dates that are indicated on the Discharge Summary and Medical Record Coversheet. In this instance, be sure to select that a "Hospital Inpatient" record is attached. Note that a Discharge Summary alone usually does not contain sufficient detail to completely code an inpatient hospitalization.

Observation Records

A hospital observation record must be submitted as a "One Observation" record using a range of dates. If submitted as such, the discharge date must be in the data collection year. It will be coded using Outpatient Coding Guidelines.

Electronic Medical Records

An electronic medical record (EMR) must be submitted to HPMS as a PDF. Screenshots may not be submitted in lieu of a medical record. Every page of an EMR must be attributable to the enrollee. As is the case for all records in Part C IPM, the enrollee's name is the key identifier.

Completing the Medical Record Coversheet

This section includes guidance for completing the Medical Record Coversheet during the submission process in HPMS. For step-by-step instructions for accessing and completing the coversheet in HPMS, refer to the *HPMS Part C IPM Module User Guide*.

Medical Record Coversheets are provided in HPMS in an electronic format for the CY22 Part C IPM. Hardcopy or "printable" coversheets are not provided. The Medical Record Coversheet allows HPMS users to submit documents (medical record only [MR] or medical record and attestation [MR+ATT]) or confirm no documents (No MR) for the designated enrollee CMS-HCC will be submitted. The system will allow only the Medical Record File to be uploaded as a PDF file to a Coversheet.

The Medical Record Coversheet page in HPMS displays the following information:

- **Contract Information:** Displays the Contract Name, Current Contract ID, and Sample Year Contract ID for the selected enrollee.
- **Enrollee Information:** Displays details about the selected enrollee including the Enrollee ID, Medicare Beneficiary Identifier (MBI), Date of Birth (DOB), Last Name, and First Name. **Note:** When completing the submission process in HPMS, ensure the enrollee on the coversheet matches enrollee on the medical record. Submitting a medical record for the wrong enrollee may lead to a PHI/PII issue and will result in an invalid submission.
- **Designated CMS-HCCs:** Displays one row for each set of sampled CMS-HCC(s), including V24 CMS-HCC(s), V21 ESRD CMS-HCC(s), or both, combined based on diagnosis code(s), Hierarchy Indicator, ICD-10-CM Codes originally submitted for payment, and Submission Count. All the enrollee's sampled CMS-HCCs are available for designation on each Medical Record Coversheet. **Note:** If the medical record documents more than one of the sampled CMS-HCCs for the enrollee, select all applicable CMS-HCCs when completing the Medical Record Coversheet and submit the record only **once**. Please avoid submitting the same medical record documentation multiple times for the same or different CMS-HCC(s).

Selecting the Correct Document Type

Document Type Selection Options in HPMS
When completing the Medical Record Coversheet in HPMS, your MA Organization will be required to select a document type for the submission. The document type indicates which coding guidelines (Inpatient or Outpatient) should be applied. MA Organizations select one of the following document type options in HPMS:

- **One Physician Specialist/Hospital Outpatient Record:** This type of record is submitted for one date of service and can be a physician office visit; a standalone hospital outpatient visit (for example, an emergency room visit or outpatient procedure report); a standalone document from an inpatient stay (Consult, Progress Note, History & Physical, Emergency Room or Operative Report); a Health Risk Assessment (HRA); or a visit with a physical therapist, occupational therapist, or Speech Language Pathology (not occurring in an inpatient setting).
- **One Observation Record:** This type of record documents that the patient was admitted for Observation status for a 1-2 day stay and never changed to inpatient status.
- **One Hospital Inpatient Record:** This type of record must include both an Admit Date and a Discharge Date/Discharge and can be a full inpatient record or an inpatient rehabilitation record.

Document Type Definitions
To assist in understanding document types, the following information details how CMS defines record types for Part C IPM:

- **Hospital Inpatient Record:** As discussed in the *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide,* hospital inpatient services are provided by an acute care hospital or rehab hospital where a patient is admitted to the facility for at least one overnight stay. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. Observation turns into inpatient level of care when the needs of the patient or the services rendered reach a level of care that can only be safely rendered at an inpatient level. The patient must meet all of the requirements for inpatient status and should not be converted to inpatient just based on the time spent in the hospital.

  Hospital inpatient records are acceptable for Part C IPM and will be coded using inpatient coding guidelines.

- **Hospital Outpatient Record:** As discussed in the *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide*, hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization.

  Hospital outpatient records are acceptable for Part C IPM and will be coded using outpatient coding guidelines.

- **Observation Record:** Observation admissions are typically under 24 hours, but longer observations are possible. The record will be reviewed for an observation or admission order to determine if the record is a true observation record. Observation records are acceptable for Part C IPM as an outpatient provider type. The first date of service will be used for the date of service, and the record will be coded using outpatient coding guidelines. All dates of service, regardless of the length of stay, will be reviewed as part of the admission.

- **Physician Specialty Record:** A physician specialty record is an encounter performed by a physician or provider that works in an inpatient facility but is not employed by the facility and, therefore, bills for the individual service. Examples include a History and Physical, Inpatient Progress Note, Op Note, Anesthesiologist Note, and a doctor visit to a resident in a nursing home or Skilled Nursing Facility (SNF). These records are acceptable for Part C IPM and will be coded using outpatient coding guidelines for one date of service.

  A physician specialty record can also be an office visit note or clinic note from a free-standing facility, such as oncologist, urologist, PT, OT, PCP, or urgent care. These types of records are acceptable for Part C IPM and will be coded using outpatient coding guidelines.

- **Ancillary Service Notes:** Ancillary services are typically employees of the facility, and their findings are under the responsibility of the attending physician. These services are not considered separate professional physicians/practitioners. Ancillary service notes are **not** acceptable for Part C IPM when submitted from an inpatient stay (regardless of whether they are submitted as an inpatient or outpatient provider type record). For example, Physical Therapy, Occupational Therapy, and Speech and Language Therapy provided during an inpatient stay are not acceptable.

Entering the Correct Date(s) of Service

The date(s) of service on the coversheet should match the date(s) of service on the medical record.

- For **One Physician Specialist/Hospital Outpatient Record**, enter the one date of service documented in the record.

- For **One Observation Record**, enter a date range using the first day to the last day of the Observation stay.
- For **One Hospital Inpatient Record**, enter a date range using both the Admit Date and Discharge Date documented in the record.

CMS-Generated Attestations

This section includes information on completing and submitting CMS-Generated Attestations for Physician Specialist/Hospital Outpatient medical records lacking the necessary provider signature and/or credentials. CMS-Generated Attestations will be accepted only for medical records that the MA Organization indicates on the coversheet and should be coded according to the physician/outpatient coding guidelines (https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf for dates of service from 10/01/2020 – 09/30/2021 and https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf for dates of service on or after 10/01/2021).

As previously stated, medical records submitted for Part C IPM that do not contain signatures or physician/practitioner credentials will result in errors during the Part C IPM medical record review process.

To mitigate signature and credential-related errors, CMS allows MA Organizations participating in Part C IPM to submit CMS-Generated Attestations when the medical record lacks necessary signatures and/or credentials. MA Organizations are not required to submit an attestation; however, if they choose to do so, they must use the CMS-Generated Attestations. CMS-Generated Attestations will be accepted only for physician/outpatient medical records. Instructions for completing the CMS-Generated Attestation are provided below.

Included in your HPMS Enrollee Data Package[4] is one pre-formatted CMS-Generated Attestation for each enrollee in the CY22 Part C IPM Enrollee Data. MA Organizations may need to print multiple copies of the pre-formatted CMS-Generated Attestation for an enrollee if there are multiple physician/outpatient records with signature and/or credential problems being submitted for that enrollee. A CMS-Generated Attestation completed by a physician or other practitioner must be submitted with the related medical record for CY22 Part C IPM and in accordance with the instructions provided herein.

CMS-Generated Attestations must be signed by physicians/practitioners who attest responsibility for conducting and documenting the health services in the accompanying physician or outpatient medical record that the MA Organization submits. By signing and documenting credentials on the attestation and identifying the date of service, physicians/practitioners are attesting to the medical record entry being submitted for CY22 Part C IPM.

Each CMS-Generated Attestation contains a CY22 Part C IPM project-specific identifier at the bottom of the page (i.e., Enrollee ID). This identifier is used to mask enrollee and diagnosis-related information across the Part C IPM activity. Do NOT alter this information in any way.

CMS-Generated Attestations that are not filled out completely as directed will not be accepted. Instructions for completing each section of the CMS-Generated Attestation are as follows:

Section I-Enrollee Information

This section should be used by the MA Organization to match the CMS-Generated Attestation to the appropriate medical record.

1. This section is pre-populated with:
    - Last Name of Enrollee
    - First Name of Enrollee
    - Date of Birth of Enrollee
    - Medicare Beneficiary Identifier (MBI)
    - MA Contract Name
    - Current Contract ID

[4] The Enrollee Data Package refers to the following set of files in each MA Organization's HPMS Part C IPM Document Library: Enrollee Data List, Data Dictionary for Enrollee Data List, CMS-Generated Attestation Form, Hospital Letter, and Provider Letter.

Do NOT alter any pre-populated information in this section.

Section II-Attestation Statement

This section should be completed by the physician/practitioner who conducted the health service and documented the medical record being submitted for review.

1. The MA Organization sends the CMS-Generated Attestation along with the medical record request to the physician/practitioner who conducted the health service.
2. The physician/practitioner prints his/her name and credentials in the body of the CMS-Generated Attestation statement, enters the date of service for the medical record to which s/he is attesting, then signs and dates the CMS-Generated Attestation. An electronic signature is acceptable; however, a stamped signature is not.
3. The physician/practitioner returns the CMS-Generated Attestation, along with the medical record, to the requesting MA Organization. Providers should not send any materials to CMS directly.
4. The MA Organization packages the CMS-Generated Attestation along with the medical record into a Medical Record File and electronically uploads it to HPMS. The Medical Record Coversheet is prepended to the Medical Record File (see *HPMS Part C IPM Module User Guide* for screenshots detailing these steps).

Submitting a CMS-Generated Attestation for a Face-to-Face Physician Encounter that Occurred During an Inpatient Admission and Coded According to Outpatient Coding Guidelines

If your MA Organization chooses to submit one date of service from an inpatient record (e.g., History and Physical, Consultation, Discharge Summary, Progress Note, etc.), a CMS-Generated Attestation may be completed by the attending physician for that single date of service. Each CMS-Generated Attestation must be signed by the physician/practitioner who attests responsibility for conducting and documenting the health services in the accompanying physician or outpatient medical record that the MA Organization submits. When submitting the CMS-Generated Attestation and associated medical record, your MA Organization will be required to identify the type of record being submitted. Based on your selection, the following may occur:

- If “One Physician Specialist/Hospital Outpatient Record” is selected, only Outpatient Coding Guidelines will apply, and a CMS-Generated Attestation may be attached and submitted.
- If “One Observation Record” is selected, only Outpatient Coding Guidelines will apply, and a CMS-Generated Attestation **cannot** be submitted.
- If “One Hospital Inpatient Record” is selected, only Hospital Inpatient Coding Guidelines will apply, and a CMS-Generated Attestation **cannot** be submitted.

Referencing a Date of Service on a CMS-Generated Attestation

Date ranges or multiple dates of service cannot be entered on a CMS-Generated Attestation. A CMS-Generated Attestation will be accepted only for a medical record for which the MA Organization makes a Medical Record Coversheet entry indicating “One Physician Specialist/Hospital Outpatient” medical record submission. The physician/practitioner who conducted the health service and documented the medical record being submitted for review should enter the date of service for the medical record to which s/he is attesting. A CMS-Generated Attestation may be completed by the attending physician for a single date of service.

Attestation Requirements and Considerations

- Only a CMS-Generated Attestation will be accepted and eligible for consideration for outpatient medical records lacking the necessary provider signature and/or credentials. MA Organizations cannot produce their own version of the CMS-Generated Attestation or submit any other type of attestation document.
- MA Organizations may use CMS-Generated Attestations to address signature and/or credential-related discrepancies for physician or outpatient medical records. CMS-Generated Attestations may not be used to address signature and/or credential-related discrepancies found on inpatient medical records and will not be used to resolve coding and other types of discrepancies.

- The CMS-Generated Attestation cannot be altered or edited. This includes, for example, striking out pre-populated words and replacing them with hand-written replacement words. In addition, information completed by the physician or practitioner cannot be altered.
- CMS-Generated Attestations may only be signed by the physician/practitioner whose medical record is being submitted for validation of the CMS-HCC.
- Physicians/practitioners must submit signed CMS-Generated Attestations directly to the MA Organization. Physicians/practitioners must not submit documentation directly in HPMS or to CMS.
- CMS-Generated Attestations must have only one date of service.
- CMS-Generated Attestations must be submitted via HPMS in accordance with these CMS submission instructions with a medical record (in a single PDF file).
- There will not be another opportunity to submit CMS-Generated Attestations after the submission deadline.
- Submission of CMS-Generated Attestations is voluntary and not required.

Preparing the Medical Record File

Your MA Organization is required to submit medical record documentation for the enrollee CMS-HCC(s) it is responsible for validating. To do so, the MA Organization must create a Medical Record File (or files), as appropriate. Each Medical Record File must contain one PDF image of one completed CMS-Generated Attestation (if applicable) and one medical record. Please note that if the medical record documents more than one of the sampled CMS-HCCs for the enrollee, you should select all applicable CMS-HCCs on the Medical Record Coversheet and submit the record only **once** to validate multiple CMS-HCCs. Please avoid submitting the same medical record documentation multiple times.

Your MA Organization will attach this Medical Record File to an electronic Medical Record Coversheet for submission in HPMS.

Your MA Organization will package the CMS-Generated Attestation (*if applicable*) together with a medical record as follows:

1. The documentation contained within the Medical Record File should be in the following order:
   - Completed CMS-Generated Attestation (*if applicable*)
   - Medical record

2. Prepare each Medical Record File containing one completed CMS-Generated Attestation (*if applicable*), and one medical record in a PDF format.
   - Only submit one medical record with one Medical Record File. Do not submit multiple medical records within a single Medical Record File. More than one CMS-HCC may be supported in a single Medical Record File.
   - Submission of CMS-Generated Attestations is voluntary and not required. If a completed CMS-Generated Attestation is submitted, it must appear as the first page within the Medical Record File.

Medical Record File Naming Convention

MA Organizations must ensure that all submissions are named and attached according to CMS instructions. Each Medical Record File containing the CMS-Generated Attestation (*if applicable*), and the supporting medical record must have a file name. When naming the file, please adhere to the following:

1. Must be less than 100 characters
2. Does not contain PHI or PII
3. Part C IPM Enrollee ID is acceptable in the configuration of the file name (but not required)

Checking the Medical Record File Before Submission

After the Medical Record File has been prepared according to these instructions, your MA Organization should complete the Medical Record Coversheet and upload the Medical Record File in HPMS according to the HPMS Plan User Guide.

When attaching the Medical Record File to the Medical Record Coversheet in HPMS, your MA Organization will be required to identify the type of record being submitted. If "One Physician Specialist/ Hospital Outpatient Record" or "One Observation Record" is selected, only Outpatient coding guidelines will apply. If "One Hospital Inpatient Record" is selected, only Inpatient coding guidelines will apply. Ensure the conditions in the inpatient medical record are documented and authenticated by an acceptable risk adjustment physician specialty.

Check the Medical Record File submission to ensure that:

- The medical record matches the File Content selection that your MA Organization will make on the Medical Record Coversheet.
- The medical record contained in the file corresponds with the Medical Record Coversheet for which it is being submitted.
- The file does not contain multiple medical records.
- All attached images are legible.

All Medical Record Coversheets and associated Medical Record Files must be submitted by the submission deadline of **11:59 p.m. PT on Thursday, May 9, 2024**. MA Organizations will receive feedback on the validity of submitted medical records via HPMS. MA Organizations and their providers must not submit documentation to CMS directly.

Feedback Available Within HPMS

MA Organizations will receive four types of feedback on medical record submissions during the submission period:

1. **File format feedback** is available in HPMS once the medical record is attached to the Medical Record Coversheet and the Medical Record Coversheet is submitted.
2. **Validity feedback** for medical records and attestations will be available within HPMS once the finalized medical record has gone through medical record intake.
3. **Interim coding feedback** will be provided to the MA Organization via the Interim Findings Reports, which will be made available in HPMS.
4. **HCC outcomes feedback** will be available in the Part C IPM *HCC Outcomes Detail Report,* which will be generated daily and available for download from Reports Tab in HPMS.

The feedback provided to your MA Organization can be used to submit or resubmit another medical record prior to the submission deadline. CMS encourages MA Organizations selected for CY22 Part C IPM to submit medical records as soon as possible. This will allow your MA Organization to address file format issues, medical record invalidity, and attestation validity feedback via HPMS in a timely manner. CMS cannot guarantee validity feedback will be provided in time to take necessary action, such as submitting another medical record prior to the submission deadline, if a submission occurs close to the submission window deadline. Additional information on the feedback provided to MA Organizations during the CY22 Part C IPM submission window is available in the *HPMS Part C IPM Module User Guide*.

File Format Feedback

File format feedback is available immediately after the MA Organization uploads a Medical Record File into HPMS. Because this feedback is based on the medical record, feedback cannot be provided for Medical Record Coversheets submitted without a Medical Record File attached.

A confirmation message will be displayed on the top of the page upon successful upload of a Medical Record File. If any of the file format criteria are not met, an error message is displayed with the reason for failure on the top of the screen.

To avoid file format issues, the Medical Record File must meet the following criteria:

- Must be a PDF file
- File name is less than 100 characters
- File size is less than 50MB
- PDF is not password protected
- PDF does not have bookmarks or binders
- PDF is not locked for editing
- PDF is not encrypted

After correcting any file format issues, click the “Submit” button to complete the submission and return to the Enrollee Dashboard.

Validity Feedback

Medical Record Feedback on Validity Status

CMS coders will provide validity feedback for medical records and attestations throughout the submission window. Evaluation criteria will include basic checks on the validity of the submitted documentation. HPMS users will log in to the system to view information about submission validity.

Medical records may be determined to be invalid for Part C IPM if they fail to meet validity checks that include the following:

- Does the medical record correctly identify the sampled beneficiary?
- Is the medical record signed?
- Is the name on the medical record an acceptable variance of the name of the sampled beneficiary?
- Is there a date on the medical record?
- Is the medical record from a valid source?
- Does the medical record confirm an acceptable credential/specialty?
- Is the date on the medical record within the data collection period?
- Is the record free from other issues not otherwise addressed through the above checks?

Attestation Feedback on Validity Status

Attestations may be unacceptable for Part C IPM if they fail to meet evaluation checks that include the following:

- Is it a CMS-Generated Attestation? (**Note:** Plan-generated attestations or altered CMS-Generated Attestations are not acceptable.)
- Does the signature on the CMS-Generated Attestation include an acceptable physician/provider credential/specialty?
- Does the date of service entered on the CMS-Generated Attestation match the date of service entered on the Medical Record Coversheet and the submitted medical record?
- Is the CMS-Generated Attestation complete?
- Is the CMS-Generated Attestation signed by the provider who conducted the health service?
- Is the CMS-Generated Attestation for the correct enrollee?
- Is the pre-populated section of the CMS-Generated Attestation unaltered?
- Is the CMS-Generated Attestation legible?
- Is the CMS-Generated Attestation associated with a Physician Specialist/ Hospital Outpatient/Observation record?
- Is the CMS-Generated Attestation free from other issues not otherwise addressed through the above checks?

MA Organizations can check the validity of a medical record and attestation in HPMS during the submission window once the file has undergone the intake process. Refer to pages 12 – 17 of the *HPMS Part C IPM Module User Guide* for details on reviewing medical record and attestation validity.

Interim Coding Feedback

Your MA Organization will receive two (2) Interim Findings Reports (IFRs), which will provide interim coding results on the medical record submissions. The IFRs will show whether the sampled CMS-HCC for the enrollee can be validated from the medical record submitted. In cases that involve hierarchical CMS-HCCs, if the same level or a higher manifestation of the CMS-HCC is found, then the report will show the sampled CMS-HCC as "found." If a lower manifestation of the sampled CMS-HCC is found during the coding process, the CMS-HCC will appear as "not found". This is so the MA Organization can continue to attempt to validate the CMS-HCC at the level sampled. The report will not display the exact manifestations of the CMS-HCCs which are found during medical record review. This feedback should be used to submit a new or corrected medical record prior to the submission deadline.

MA Organizations are encouraged to submit Medical Record Files early in the submission window to take advantage of the IFRs. The IFR submission cutoff dates are as follows:

- IFR #1 Submission Cutoff Date: 11:59 p.m. PT on Tuesday, February 20, 2024
- IFR #2 Submission Cutoff Date: 11:59 p.m. PT on Tuesday, March 26, 2024

HCC Outcomes Feedback

Your MA Organization will be able to review HCC outcomes using the Part C IPM *HCC Outcomes Detail Report,* which is a downloadable Excel report that displays a list of all CMS-HCCs reviewed within the sample, CMS-HCC outcomes, and MA Contract Suggested Action to the plan user. This report is generated daily and available for download from the HPMS Part C IPM module Reports Tab.

Contact Information

If you have any questions or concerns regarding the Part C IPM process, these instructions, or technical aspects of the medical record review, please email PartC_IPM@cms.hhs.gov and reference "Part C IPM" in the subject line of your email.

If you require technical assistance, including assistance related to your HPMS login, password resets, status on your new account, or access to the "Part C IPM" module, please email hpms_access@cms.hhs.gov.

If you have general HPMS questions not related to HPMS User Access, please email hpms@cms.hhs.gov.

Do not direct providers to any CMS mailboxes. Do not send PHI or PII to any CMS mailboxes. In an effort to address your questions or concerns, please only include the relevant Medical Record Coversheet ID or Enrollee ID listed on the Enrollee List provided to your MA Organization in your communications when identifying the beneficiary. Additionally, please avoid emailing screenshots of findings reports and medical records, as these often contain PHI or PII. Please reference report columns and medical record page numbers instead, as applicable.

Deadline Reminders

- IFR #1 Submission Cutoff Date: 11:59 p.m. PT on Tuesday, February 20, 2024
- IFR #2 Submission Cutoff Date: 11:59 p.m. PT on Tuesday, March 26, 2024
- CY22 Part C IPM Submission Deadline: 11:59 p.m. PT on Thursday, May 9, 2024

Lessons Learned with Part C IPM

MA Organizations that participated in prior Part C IPM activities provided valuable feedback about the medical record request process. Summarized below are suggested practices for your CY22 Part C IPM participation:

- Designate a point of contact within your MA Organization for providers to contact if they have questions about your medical record request. Be sure to include this individual's name and contact information on all medical record requests you send to providers.
- Identify a contact person at the hospital or physician's office prior to sending the request for medical records, and coordinate with that person to ensure the request is received and understood.
- Include the Physician Letter or Hospital Letter, as appropriate, and HIPAA Fact Sheet with your initial medical record request.
- For physician/practitioner office and hospital outpatient visits, send the CMS-Generated Attestation to the provider with the initial medical record request so the provider will have the CMS-Generated Attestation on hand in case a signature and/or credential from the physician/practitioner who conducted the health service is missing.
- Confirm receipt of the medical record request with the provider's office. This is especially important if faxing the medical record request since fax coversheets may become separated from the other pages.
- Maintain communications with the providers throughout the medical record request period.
- Set reasonable deadlines for hospitals and providers to respond to your request for medical records as appropriate. CMS affords MA Organizations 16 weeks to complete their submissions.
- Track requests and follow up with providers who have not responded in a timely manner.
- Plan accordingly to ensure that Medical Record Files are submitted in a timely manner. It may require more effort to obtain medical records from:
    - Specialists;
    - Non-contracted providers;
    - Hospital outpatient or primary care provider settings.
- Confirm that all information in the records received corresponds to the correct enrollee, including enrollee name and date of birth.
- Submit Medical Record Files early in the submission window to take advantage of feedback provided in the *HCC Outcomes Detail Report* and IFRs.
- Confirm whether the medical record can support more than one CMS-HCC for the enrollee, if applicable. If the medical record supports more than one CMS-HCC, select all applicable CMS-HCCs when completing the Medical Record Coversheet and submit the record only **once**. CMS will not review confirmed duplicate records.

Appendix A: CMS-HCCs and Physician Specialties

CMS-HCCs

Risk Scores and Relative Factors:

For PY22, CMS uses the 2020 CMS-HCC model (also known as the V24 model) for non-ESRD enrollees and the 2020 ESRD model (or V21 ESRD model) for ESRD enrollees. CMS calculates 100% of the risk score calculated with the V24 CMS-HCC and V21 ESRD models, using diagnoses from encounter data and Fee-for-Service (FFS).

The 2022 Rate Announcement can be found at the following Web page: https://www.cms.gov/files/document/2022-announcement.pdf. Pertinent information on the calculation of PY22 risk scores using the CMS-HCC models is found on page 5 of the 2022 Rate Announcement. The V24 and V21 ESRD model CMS-HCCs and relative factors for each segment appear in Attachment VI of the 2020 Rate Announcement: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

Disease Hierarchies for the CMS-HCC Risk Adjustment Models:

Disease hierarchies address situations when multiple levels of severity for a disease, with varying levels of associated costs, have been reported for a beneficiary. The CMS-HCC risk adjustment models use the CMS-HCC that represents the highest disease severity level when calculating the risk score and disregards the other CMS-HCCs within that hierarchy. CMS publishes, in the Rate Announcement, a list of disease hierarchies each time the CMS-HCC risk adjustment model is recalibrated. The list of hierarchies contains information regarding which CMS-HCCs are dropped when a CMS-HCC of a higher severity is assigned.

The hierarchies for the 2020 CMS-HCC model (V24, previously known as the Alternative Payment Condition Count Model) and ESRD model are published in the 2020 Rate Announcement: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf. You will find Table VI-4 Disease Hierarchies for the 2020 Alternative Payment Condition Count Model on page 84 and Table VI-12 List of Disease Hierarchies for the ESRD Model on page 101.

Diagnosis Codes for PY22:

For PY22, diagnoses for 2021 dates of service (from January 1, 2021 through December 31, 2021) are coded using the ICD-10-CM coding system.

The mappings of ICD-10-CM codes to CMS-HCCs for the ESRD V21 model V24 CMS-HCC risk adjustment model are available on the CMS website. To obtain this list, go to https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsrisk-adjustors/2022-model-softwareicd-10-mappings and click on “2022 Midyear Final ICD-10 Mappings.” The following columns apply to the 2022 Part C IPM:

a. Diagnosis Code (Column A)
b. Description (Column B)
c. CMS-HCC ESRD Model Category V21 (Column C)
d. CMS-HCC Model Category V24 (Column E)
e. CMS-HCC ESRD Model Category V21 for 2022 Payment Year (Column G). All codes

indicated as "Yes" were valid for PY22 payments with the ESRD V21 model.

f. CMS-HCC Model Category V24 for 2022 Payment Year (Column I). All codes indicated as "Yes" were valid for PY22 payments with the V24 model.

Physician Specialties

Below is the list of acceptable physician specialties for risk adjustment and their corresponding codes. This list is to be used to determine whether a particular physician specialty is an acceptable risk adjustment provider. Only acceptable physician specialty medical records will be accepted for this Part C IPM.

Acceptable Physician Specialty Types for 2022 Payment Year (2021 Dates of Service) Risk Adjustment Data Submission

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	29	Pulmonary Disease	81	Critical Care (Intensivists)
2	General Surgery	33*	Thoracic Surgery	82	Hematology
3	Allergy/Immunology	34	Urology	83	Hematology/Oncology
4	Otolaryngology	35	Chiropractic	84	Preventive Medicine
5	Anesthesiology	36	Nuclear Medicine	85	Maxillofacial Surgery
6	Cardiology	37	Pediatric Medicine	86	Neuropsychiatry
7	Dermatology	38	Geriatric Medicine	89*	Certified Clinical Nurse Specialist
8	Family Practice	39	Nephrology	90	Medical Oncology
9	Interventional Pain Management	40	Hand Surgery	91	Surgical Oncology
10	Gastroenterology	41	Optometry	92	Radiation Oncology
11	Internal Medicine	42	Certified Nurse Midwife	93	Emergency Medicine
12	Osteopathic Manipulative Medicine	43	Certified Registered Nurse Anesthetist	94	Interventional Radiology
13	Neurology	44	Infectious Disease	97*	Physician Assistant
14	Neurosurgery	46*	Endocrinology	98	Gynecologist/Oncologist
15	Speech Language Pathologist	48*	Podiatry	99	Unknown Physician Specialty
16	Obstetrics/Gynecology	50*	Nurse Practitioner	C0*	Sleep Medicine
17	Hospice And Palliative Care	62*	Psychologist	C3*	Interventional Cardiology
18	Ophthalmology	64*	Audiologist	C5*	Dentist
19	Oral Surgery (Dentists only)	65	Physical Therapist	C6	Hospitalist
20	Orthopedic Surgery	66	Rheumatology	C7	Advanced Heart Failure

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
					and Transplant Cardiology
21	Cardiac Electrophysiology	67	Occupational Therapist	C8	Medical Toxicology
22	Pathology	68	Clinical Psychologist	C9	Hematopoietic Cell Transplantation And
23	Sports Medicine	72*	Pain Management	D3*	Medical Genetics and Genomics
24	Plastic And Reconstructive Surgery	76*	Peripheral Vascular Disease	D4	Undersea and Hyperbaric Medicine
25	Physical Medicine And Rehabilitation	77	Vascular Surgery	D5	Opioid Treatment Program
26	Psychiatry	78	Cardiac Surgery	D7*	Micrographic Dermatologic Surgery (MDS)
27	Geriatric Psychiatry	79	Addiction Medicine	D8	Adult Congenital Heart Disease (ACHD)
28	Colorectal Surgery (formerly Proctology)	80	Licensed Clinical Social Worker		

*Indicates that a number has been skipped.
Source:
https://www.csscoperations.com/internet/csscw3.nsf/DIDC/HSEK7AHN1H~Encounter%20and%20Risk%20Adjustment%20Program%20(Part%20C)~References